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New Beginnings
Counseling Center, PLLC

Adult Client Information

Name: _____ Age: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation/Job Title: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Person Responsible for Payment (if different): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

How did you hear about New Beginnings Counseling Center (NBCC)? _____

Appointment Reminders and Additional Contact from NBCC: Currently, appointment reminders are made via phone. However, in the future, NBCC is considering automated appointment reminders. When this change is made, how would you like to receive appointment reminders? (Check ONE)

☐ Text to: _____ ☐ Email to: _____

☐ Continue calling me at: _____

May your provider leave voicemails regarding session content and/or mental health information at the number provided for appointment reminders? (This includes return phone calls regarding questions you may have.) ☐ **Yes** ☐ **No**

Please Note: A 24-hour cancellation notice is required to avoid a possible cancellation fee.

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Primary Care Physician (PCP): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Psychiatrist (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

If you are receiving testing services, to which of the above providers would you like the results sent? **To insure your results are sent as quickly as possible, please provide ALL contact information.**

☐ **Primary Care Physician** ☐ **Psychiatrist** ☐ **Both** ☐ **Neither** ☐ **N/A**

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Authorization to Release Information

I authorize NBCC to release the following information to my providers:

Primary Care Physician

- ☐ Initial notification that I am receiving services at NBCC
- ☐ Any applicable mental health information
- ☐ Any applicable substance abuse information
- ☐ Only medical information
- ☐ I DO NOT authorize the release of any information to my PCP.

Psychiatrist

- ☐ I do not currently have a psychiatrist
- ☐ Initial notification that I am receiving services at NBCC
- ☐ Any applicable mental health information
- ☐ Any applicable substance abuse information
- ☐ Only medical information
- ☐ I DO NOT authorize the release of any information to my psychiatrist.

For more information about this release of information, please review the Provider-Client Service Agreement. You may revoke this authorization at any time except in regards to information that has already been released. Unless otherwise requested by you in writing, this authorization will expire one year after treatment has ended.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative and Description of Personal Representative's Authority (if applicable)

Consent to Receive Services

Your signature below indicates the following:

- A copy of the NBCC Provider-Client Service Agreement and the NBCC Notice of Privacy Practices has been made available to you.
- You consent to accept these policies as a condition of receiving mental health services.
- You consent to receive appointment reminders from NBCC.
- You consent to contact of the person you identified in an emergency.
- Any questions you have regarding this information have been addressed.
- You acknowledge your right to ask questions about these policies at any time.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative and Description of Personal Representative's Authority (if applicable)

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Personal and Family Information

What brings you to counseling today? _____

_____

What are your goals for counseling? _____

_____

History of Mental Health Services: Have you received mental health services in the past? ☐ **Yes** ☐ **No**

If yes, services received: ☐ Counseling ☐ Assessment ☐ Psychiatric Care ☐ Hospitalization

Briefly describe your experience (including clinicians and diagnoses): _____

_____

Have you previously taken medications for mental health concerns? ☐ **Yes** ☐ **No**

If yes, please list medications, when taken, and reason no longer taking: _____

_____

Legal Involvement: Do you have any current or expected legal involvement (including divorce and custody proceedings)? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

Are you currently under an order of protection? ☐ **Yes** ☐ **No** If yes, please explain: _____

_____

Marital Status: ☐ Single ☐ Married (how long? _____) ☐ Cohabitating ☐ Separated

☐ Divorced (what year? _____) ☐ Widowed ☐ Other: _____

On a scale of 1-10, how do you rate your overall satisfaction with your marriage? _____ ☐ N/A

Are your parents divorced? ☐ **Yes** ☐ **No** If so, how old were you? _____

Regarding Your Spouse (if applicable): Has your spouse been married previously? ☐ **Yes** ☐ **No**

Are your spouse's parents divorced? ☐ **Yes** ☐ **No** If so, how old was your spouse? _____

Spouse's Name: _____ Occupation: _____

Household Information: Please provide the requested info for those currently living in your home:

Name	Age	Relationship to Self

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Psychological Concerns (check all that apply)

Feelings
- ☐ Tension
- ☐ Rage
- ☐ Low self-worth
- ☐ Dread
- ☐ Boredom
- ☐ Loneliness
- ☐ Guilt
- ☐ Anxiety/Panic
- ☐ Hopelessness
- ☐ Helplessness
- ☐ Worthlessness
- ☐ Depression
- ☐ Other: _____

Thoughts
- ☐ Vivid Dreams/Nightmares
- ☐ Persecution
- ☐ Hearing Voices
- ☐ Seeing Visions
- ☐ Being out of Body
- ☐ Thoughts Confused/Controlled
- ☐ Racing Thoughts
- ☐ Obsessive Thoughts
- ☐ Suicidal Thoughts
- ☐ Homicidal Thoughts
- ☐ Other: _____

Behaviors
- ☐ Self-Harm
- ☐ Anger Outbursts
- ☐ Eating Issues
- ☐ Spending Issues
- ☐ Stealing
- ☐ Gambling
- ☐ Poor Decision-Making
- ☐ Irresponsibility
- ☐ Obsessive/Compulsive Behaviors
- ☐ Impulsiveness
- ☐ Drug or Alcohol Use
- ☐ Other: _____

Specific Fears
- ☐ Crowds
- ☐ Small Spaces
- ☐ Death
- ☐ Losing Control/Sanity
- ☐ Being Alone
- ☐ Other: _____

Trauma History
- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Violent Crime
- ☐ Domestic Violence
- ☐ Witness Violent Crime/Death
- ☐ Other: _____

Spiritual Concerns
- ☐ Alienated
- ☐ Uninvolved
- ☐ Doubt
- ☐ Other: _____

Social and Occupational Concerns (Check all that apply)

Intimate Relationships
- ☐ Unfaithful Spouse/Infidelity
- ☐ Pregnancy before Marriage
- ☐ Fertility Issues
- ☐ Work Interference
- ☐ Conflict/Control Issues
- ☐ Sexual Issues
- ☐ Separation/Divorce
- ☐ Post-Divorce Issues
- ☐ Jealousy
- ☐ Other: _____

Sexuality
- ☐ Identity Concerns
- ☐ Changed Desire
- ☐ Misconduct
- ☐ Impotence
- ☐ Fearful/Inhibited
- ☐ Addiction/Excess
- ☐ Other: _____

Family
- ☐ Blended Family
- ☐ Custody Issues
- ☐ Conflict with In-Laws
- ☐ Domestic Violence
- ☐ Death
- ☐ Conflict/Fight
- ☐ Separation
- ☐ Illness
- ☐ Issues with Children
- ☐ Housing Issues
- ☐ Elderly Parents
- ☐ Other: _____

Finances
- ☐ Debt
- ☐ Bankruptcy
- ☐ Bad Checks
- ☐ IRS Problems
- ☐ Other: _____

Education/Occupation
- ☐ Lack of Career Direction
- ☐ Frequent Job Changes
- ☐ Poor Performance
- ☐ Dissatisfaction
- ☐ Harassment/Discrimination
- ☐ Lack of Education/Training
- ☐ Potential Job Loss
- ☐ Other: _____

Leisure
- ☐ No Free Time
- ☐ No Outside Interests
- ☐ Boredom
- ☐ Lack of Enjoyment
- ☐ No Friends
- ☐ No Social Outlets
- ☐ Other: _____

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Physical Health Concerns (Check all that apply)

Changes In:
- ☐ Sleep Habits
- ☐ Appearance/Hygiene
- ☐ Energy Level
- ☐ Weight
- ☐ Other: _____

Cardiac Health
- ☐ Shortness of Breath
- ☐ Heart Racing
- ☐ Rapid Breathing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Arrhythmia
- ☐ Mitral Valve Prolapse
- ☐ Other: _____

Digestive Health
- ☐ Nausea
- ☐ Vomiting
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Other: _____

Neurological Health
- ☐ Attention/Focus Issues
- ☐ Memory Problems
- ☐ Headaches/Migraines
- ☐ Vision Problems
- ☐ Seizures
- ☐ Head Injury
- ☐ Confusion
- ☐ History of Concussion
- ☐ Speech Problems
- ☐ Balance/Coordination Issues
- ☐ Numbness/Tingling
- ☐ Paralysis
- ☐ Dizziness
- ☐ Blackouts
- ☐ Tremors
- ☐ Other: _____

Lung Health
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Other: _____

Endocrine Health
- ☐ Diabetes
- ☐ Thyroid Issues
- ☐ Hormone-Related Issues
- ☐ Other: _____

Muscle/Bone Health
- ☐ Chronic Pain
- ☐ Back Issues
- ☐ Weakness
- ☐ Other: _____

Gynocological Health
- ☐ Menstrual Difficulties
- ☐ PMS Symptoms
- ☐ Miscarriage
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Other: _____

Other
- ☐ Skin Rash/Issues

Additional Health Information

☐ Cancer History: _____ ☐ Surgeries: _____

☐ Allergies: _____ ☐ Other: _____

How would you describe your overall health? ☐ Excellent ☐ Average ☐ Poor

Prescriptions, Over-the-Counter Medications, Herbs, and Supplements (Past 6 Months)

Name	Dose/Frequency	Condition Treated	Currently Using (Y/N)

Alcohol, Tobacco, Marijuana and Other Drugs

Substance	Amount/Frequency	Currently Using (Y/N)	Comments